



## ***SERVICE GUIDELINES***

### ***Children with Autism Spectrum Disorders***

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## **Introduction**

As lead agency for Early Intervention in New Jersey, the Department of Health and Senior Services is committed to ensuring the Early Intervention System provides appropriate services to all eligible children and their families. These services are designed to be consistent with federal mandates, developmentally appropriate, outcome-based and fiscally responsible throughout the state.

In 1999, the New Jersey Early Intervention System (NJEIS) convened an autism task force and charged the committee with enhancing the state's capacity to provide equitable access to appropriate evaluations and services for children with autism spectrum disorders. The early intervention autism task force is a statewide group, representing families and professionals throughout New Jersey. The autism task force made major contributions to the lead agency with recommendations on IFSP development and a qualitative analysis of the National Research Council's report. The recommendations of the autism task force became the foundation for the current guidelines and those involved with the autism task force are commended for their efforts and commitment to assuring quality intervention for infants and toddlers with autism.

New Jersey researched other state's policies and procedures to determine national trends in the service delivery model for children with autism. It is impossible, however, to compare states as a whole. Each state has its own political climate, definitions of eligibility, available resources and fiscal realities. States do share a common vision: provision of quality services that are beneficial to children and families.

The guidelines outlined in this document were significantly shaped by the conclusions and recommendations of the National Research Council in the book Educating Children with Autism (2001). New Jersey chose not to repeat the outstanding work of the National Research Council in reviewing research on best practice. Instead, it was decided to combine the National Research Council's recommendations, the early intervention task force recommendations and the existing policies and procedures of early intervention into cohesive guidelines and practice parameters.

These guidelines support the mission of early intervention, promote consistency in service delivery across the state and most importantly, address the specific needs of children with autism spectrum disorders and their families.

## **OVERVIEW OF EARLY INTERVENTION IN NEW JERSEY**

The Individuals with Disabilities Education Act (IDEA) is the federal law that ensures children with disabilities ages 3-21 a Free and Appropriate Education (FAPE) under Part B. Children aged birth to three are served under Part C of IDEA through the early intervention system in New Jersey. By federal law, there are 5 established functions provided at public expense to children under three and their families. The functions provided at public expense are:

- Child Find;
- Evaluation and Assessment;
- Service Coordination;
- Development and review of Individualized Family Service Plan (IFSP) including plans for transition; and
- Procedural Safeguards.

Federal regulations define early intervention as services that are:

“designed to meet the developmental needs of each child eligible under this part and the needs of the family related to enhancing the child’s development.”

### **Mission Statement**

The mission of the New Jersey Early Intervention System is to enhance the capacity of families to meet the developmental needs of children, birth to age three, who have delays or disabilities, by providing quality services and support to families and their children. Families from diverse racial, cultural and socioeconomic backgrounds will be involved in decision-making at every level of the design, implementation and evaluation of the Early Intervention System. The system will:

- Provide a family-centered approach which will be based upon the uniqueness of the family and its culture;
- Promote collaborative partnerships among the family, their community, service and health care providers, school and child care programs that strengthen and enhance family competence to develop and use lasting networks of support;
- Promote prompt service and support delivery in settings most natural and comfortable for the child and family and which foster opportunities for the development of peer relationships with children without disabilities;
- Reflect the current best practices in the field of early intervention in order to ensure uniformity of service delivery standards and yield the most positive outcome for the child and family;
- Recognize and respect the knowledge, beliefs, aspirations, values, culture and preference of families and utilize these for planning and delivery of supports and services; and
- Facilitate ongoing, system-wide, participatory evaluation to ensure an effective and efficient Early Intervention System.

**All Individualized Family Service Plans for children with autism spectrum disorders will be developed in accordance with the New Jersey Early Intervention System mission.**

### **Natural Environments**

New Jersey complies and supports the federal law and regulations that require early intervention services to be provided in the natural environment to the maximum extent appropriate. Section 303.18 defines natural environment as settings that are natural or typical for the child's age peers who have no disabilities. As per section 303.167, NJEIS ensures, that to the maximum extent appropriate, early intervention services are provided in natural environments and that the provision of services for any infant or toddler occurs in settings other than a natural environment only if outcomes cannot be achieved satisfactorily in the natural environment.

The decision of environment must be made by the team with respect for the family's concerns, resources and priorities along with the patterns of interaction with their child. Besides the child's home, there are often other natural environments that could be considered as a possibility for service delivery. These include a child care setting, a family member's home and other community programs in which children without disabilities participate.

### **Developmental Intervention**

The purpose of providing early intervention services is to promote the child and family's ability to meet the developmental outcomes the family has chosen as their priorities in the Individualized Family Service Plan (IFSP). Developmental intervention is an appropriate service for many children with Autism Spectrum Disorders. Developmental intervention can be implemented by qualified personnel of varying backgrounds meeting NJEIS personnel standards. Regardless of the instructional method, developmental intervention should be a balance between responsive teaching and directive teaching, a balance between following a child's lead and ensuring the child responds to specific events and a balance between self-directed learning and following the agenda of adults (Strain et al, 1998).

Developmental intervention includes (but is not limited to) these types of activities:

- teaching the family to design learning environments and materials to promote the child's acquisition of a variety of skills;
- working directly with the child;
- identifying activities and daily routines which can be utilized as learning opportunities for the child;
- sharing knowledge of child development with families;
- promoting a positive parent-child relationship as the core of intervention efforts;
- networking with and providing consultation to community providers and friends that the family chooses; and
- coordinating the intervention activities that are provided within the EI team.



### **Early Intervention Teams**

Family members and early intervention personnel form the team responsible for the development and implementation of the IFSP. The successful development and implementation of any individualized plan will be the result of cooperation and commitment between the team members. Within the team, each member has certain responsibilities.

### **Responsibilities of NJ Early Intervention System**

Early intervention is committed to the provision of:

- Qualified individuals to provide services (both coordination and intervention) to families;
- Reasonable and adequate levels of service;
- A choice of service providers when available and appropriate;
- Service coordination that explores access to available community, public and private funding resources to help families in their shared cost responsibilities; and
- Unbiased information on the full range of interventions available for children with ASD including the strengths and limitations of each.

### **Responsibilities of Family Members:**

Participation in the NJEIS indicates that families agree to:

- Share in the cost of intervention services in accordance with the NJEIS financial participation guidelines;
- Utilize approved NJEIS providers;
- Share information with team members related specifically to their child's behavior, health, IFSP and other program specifics;
- Provide materials used in interventions including, but not limited to, food, stickers, storage bins, office supplies and toys;
- Work with IFSP team members to identify routines and activities that provide opportunities for integrating intervention techniques into daily life;
- Identify and provide appropriate opportunities in the child's natural environment for intervention to occur;
- Be active and consistent in applying the techniques demonstrated by interventionists with their child; and
- Commit to "engagement" activities as part of the child's overall program.

### **AUTISM SPECTRUM DISORDERS (ASD)**

Children with autism spectrum disorder have significant impairments in the areas of socialization, communication and behavior. The full diagnostic criteria is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (2000) published by the American Psychiatric Association. In the DSM-IV-TR the umbrella term of Pervasive Developmental Disorder includes the classifications of Autistic disorder, Asperger's disorder, Rett's disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS).

"The manifestations of autism vary considerably across children and within an individual child over time. There is no single behavior that is always typical of autism and no behavior that would automatically exclude an individual child from a diagnosis of autism, even though there are strong and consistent commonalities, especially relative to social deficit" (National Research Council, 2001).

Some signs and symptoms associated with ASD include but are not limited to:

- Little or no eye contact;
- Impairment in gestural and reciprocal communication;
- Lack of joint attention;
- Lack of pretend, imitative and functional play appropriate to developmental age;
- Unusual or inappropriate fears;
- Failure to develop peer relationships appropriate to developmental age; and
- Stereotypical and repetitive behavior.

### **How is it diagnosed?**

ASD is a biologically-based disorder but it is diagnosed by behavioral characteristics and symptoms. Currently there are no biological markers or "tests" that detect autism. Clinicians make a diagnosis based on parental reports along with clinical observations of the child. In addition to the DSM-IV-TR, tools for assessing a child for autism spectrum disorders include the Autism Diagnostic Observation Scales (ADOS; Lord et al., 2000) the Autism Diagnostic Interview-Revised (ADI-R; Lord et al. 1994) and the Childhood Autism Rating Scales (CARS; Schopler et al., 1988).

### **Why use the term ASD?**

The term Autism Spectrum Disorder (ASD) has been widely adopted in professional literature because it underscores the continuum of symptom severity and is inclusive of children with varying diagnoses along the spectrum.

"It is appropriate to use autism spectrum disorder to refer to younger children because diagnoses within the autism spectrum have been found to be quite stable over time, but distinctions within the spectrum are not very reliable at young ages" (Shaw & Odom, 2001).

### **Is there a cure?**

Theories of the etiology of ASD include genetics, infectious diseases, prenatal or postnatal trauma, immune system deficiencies and metabolic disorders. There is no cure for autism spectrum disorders and the majority of children and adults with ASD will require a lifetime of supportive services (Holmes, 1997). Studies show that early detection and intervention can have significant effects on the progress and functioning level of the children. "There is not a simple direct relationship, however, between any particular current intervention and recovery from autism" (National Research Council, 2001, p.43). In addition, Izeman (1995) advised that "there is no magic cure for PDD/autism and parents must be cautious to avoid being misled by extravagant claims made by people promoting their brand of therapy".

**Purpose of Guidelines**

The primary purpose of these guidelines is to assist service coordinators, providers and families in designing quality intervention for children with autism spectrum disorders. Additionally these guidelines offer families a clear understanding of their rights and expected level of participation as a part of New Jersey's Early Intervention System.

# **GUIDELINES**

## **1. ELIGIBILITY FOR SERVICES UNDER THESE GUIDELINES**

### 1.1 Children with a diagnosis

Eligibility for receiving services is presumed for children who present with an established high risk of developmental delay due to a diagnosed physical or mental condition. Children with a confirmed diagnosis of an Autism Spectrum Disorder by a qualified physician or mental health professional can receive services under the Service Guidelines for Autism Spectrum Disorders.

### 1.2 Children without a diagnosis

Children without a formal diagnosis, but who have been evaluated and assessed by NJEIS to be showing signs, symptoms and delays associated with ASD, are also eligible to receive early intervention services under these guidelines. The information obtained through evaluation and assessment will be the basis for IFSP development and service provision. The following sections describe the procedures to be followed when ASD is suspected, but not confirmed.

## **2. Referral/Intake**

### 2.1 Face- to- face intake

Face-to-face intake is the crucial first step in helping determine the appropriate evaluation/assessment tools and team members. The NJEIS philosophy, mission, policies and procedures and potential funding resources must be discussed with the family during the referral/face-to-face intake process. The NJEIS Financial Participation Guidelines must be discussed during a face-to-face interview. This discussion clarifies perceptions and expectations, sets the stage for a relationship-based partnership, and underscores the role of early intervention (EI) in assisting the family to meet the developmental and health-related needs of the child.

### 2.2 Children with a diagnosis

When a child enters the early intervention system with a diagnosis on the spectrum, it is important to help the family gather information about the diagnosis, available supports and resources, and service delivery approaches. Consideration must be given to a family's need for specific diagnostic information as early as possible (National Research Council, 2001). The information shared with families should be guided by how recently they have received a diagnosis of ASD, their comfort level with the diagnosis and their knowledge about intervention options. A crucial role of the IFSP team will be to assist families in accessing relevant resources while supporting the family's connection to the community. The NJEIS Family Resource Book on Autism Spectrum Disorders is a thorough document that can be shared with and utilized by families (Published, 2003).

The service coordinator should request permission to receive copies of any reports, evaluations (including a copy of the diagnostic report) and recommendations that the family may already have. This information will be added to the evaluation/assessment reports done by NJEIS and factor into the development of an appropriate IFSP.

### 2.3 Children without a diagnosis

Often at intake, a child does not have a diagnosis of ASD. However, parents may describe, or service coordinators may observe, characteristics that are associated with autism and that are not appropriate for the child's developmental age.

Some behaviors indicative of autism that may be observed or parents may describe are:

- Child does not respond to his/her name;
- Child has lost previously acquired skills;
- Child does not imitate others' behavior;
- Child is rigid in routines or has very difficult transitions;
- Child does not draw attention to objects in the environment (joint attention);
- Child is not pointing by age of 12 months; and
- Child engages in repetitive or stereotypical behavior.

If the above concerns are raised during intake by the family, a person knowledgeable about ASD should be considered as part of the NJEIS evaluation team.

## **3. Evaluation/Assessment**

### 3.1 Purpose of Assessment

It is important that families and referral sources understand the purpose of the evaluation and assessment process in the NJEIS. It is the responsibility of the NJEIS evaluation and assessment teams to determine the developmental status of a child, not to offer a diagnosis. The evaluation team is responsible to determine eligibility for entry into the NJEIS. It is the task of the assessment team to gather information about the child's current levels of functioning so that appropriate intervention services can be coordinated. During assessment, the family's concerns, resources and priorities are also explored. Information from evaluation and assessment is then used to identify child and family outcomes and the services and supports that will be needed to meet these outcomes.

### 3.2 Putting together the team

These questions should be considered when determining the composition of the evaluation/assessment team for a child with, or suspected of having, ASD:

- What evaluations have already occurred?
- What reports exist that can be incorporated into the EI evaluation/assessment process?
- Are there areas of development the family has identified as a need?
- Are there any concerns that would dictate the need for a particular discipline?
- Has the family raised concerns specifically about ASD or described behaviors consistent with ASD?

### 3.3 Children with a diagnosis

**For a child with a diagnosis, the composition of the assessment team must include at least one member with knowledge and experience in the area of autism.** (see Appendix A for clarification)

A child who enters the NJEIS with a diagnosis of ASD is considered to have presumptive eligibility and is eligible to receive early intervention services. A child with a diagnosis and his/her family still proceeds through the assessment process so the team can gather important information for developing the Individualized Family Service Plan. This includes family assessment and a review of pertinent records related to the child's current health status and medical history.

The inclusion of an experienced team member will assist the family and other team members in understanding how autism impacts the unique learning characteristics of the child.

Information about a child's abilities/levels of functioning in all areas of development should be obtained through assessment, even though this information is not needed to determine eligibility. Families must be provided with this information on assessment reports.

### 3.4 Children without a diagnosis

**Assessment by an EI professional with autism knowledge is considered best practice when ASD is suspected by parent or clinician, even though the child does not have a formal diagnosis.**

**Intervention services are not contingent upon the child having a diagnosis of ASD. NJEIS is not responsible for diagnostic services unless a diagnosis is needed for eligibility or IFSP planning.**

Without a diagnosis of ASD, a child must proceed through the eligibility determination process outlined in the NJEIS policies and procedures. During evaluation and assessment, evaluators should screen for ASD as needed, using these questions (Excerpted from the M-CHAT : Robins, Fein, & Barton, 1999).

- Does your child ever use his/her index finger to point to indicate interest or to ask for something?
- Does your child ever bring objects over to show you something?
- Does your child respond to his/her name when you call?
- If you point at a toy across the room, does your child look at it?
- Does your child imitate you? (e.g., peek-a-boo)
- Does your child take an interest in other children?

**If the answer is "No" for 2 or more questions,** evaluators have a professional responsibility to inform the family that the developmental evaluation and screening questions have raised behavioral concerns that are consistent with possible autism spectrum disorder. Families should be encouraged to discuss the findings and concerns of the EI team with their primary health care provider.

### 3.5 Areas to be included in Assessment of Children with or suspected ASD

Teams should supplement their regular assessment tools with ones that assess the core characteristics and deficits typically seen in children on the spectrum, as standardized tests and developmental checklists often do not capture the unique skill profile of a child with ASD.

Assessment must result in a written report that discusses the child's functioning in the following areas:

#### Communication

- Nonverbal/ Pre-language skills (eye contact, gestures);
- Vocal behavior (words or sounds);
- Functional use of language/pragmatics;
- Listening response; and
- Receptive language skills.

#### Social skills

- Initiation of interaction (how & how often);
- Child's attachment patterns;
- Social imitation of adults, peers;
- Imitation of play skills (fine motor, gross motor); and
- Verbal imitation.

#### Behavior

- Presence of stereotypical behavior;
- Presence of self-injurious behavior;
- Reaction to transition or change; and
- Other parental concerns regarding behavior patterns.

In addition, a comprehensive assessment will provide a description of the child's sensory profile including the child's:

- Activity level;
- Taste, smell, touch response;
- Unusual fears;
- Reaction to/need for auditory input;
- Reaction to/need for visual input; and
- General responses to sensory input from environment.

## **4. IFSP DEVELOPMENT**

### 4.1 What do children with ASD need?

Children with autism spectrum disorders and their families will need direct professional contact/instruction to meet the outcomes identified on their IFSP. They also need to be involved in *engagement* activities. Using current scientific research, it is not possible to accurately predict the optimal number of hours that will be effective for any given child. Effective services can and *should* vary from child to child and family to family. Additionally, the quality of the instructional exchanges, the competence of the interventionists and the degree of continuity across interventionists and settings may be more important than the total number of hours (Strain, et al., 1998). Research does indicate that effective intervention is intensive

and requires involvement from both professionals and families. Following the recommendations from the National Research Council, modifying them to the needs of infants and toddlers and with consensus from the NJEIS Autism Task Force, NJEIS has set the following guidelines regarding service provision.

#### 4.2 Writing Outcomes

IFSP teams must develop meaningful, functional and measurable outcomes that promote generalization of skills across settings. Outcomes should not be vague or based on development of isolated skills. Outcomes such as child "will talk" or "will behave" do not provide clear guidance for determining progress. Outcomes should be able to be accomplished within 3-6 months and should affect a child's participation in the community and family life. Outcomes should include the development of social skills, verbal and non-verbal communication, play, fine and gross motor skills, and replacement of inappropriate behaviors

#### 4.3 Engagement

**The New Jersey Early Intervention System recommends that children with ASD have at least 15-20 hours per week of active engagement. Recommended hours are inclusive of any and all time child is engaged with adults and other children, including family members and interventionists.**

Engagement is defined by the National Research Council (2001) as "sustained attention to an activity or person" (p.160). In early intervention, engagement is planned and purposeful activities by the family and interventionists with the child. It is important to realize and remember that children with ASD can and do learn in everyday activities when those activities are structured around the child's abilities, goals and tolerances. For example, in the grocery store, one child may be able to retrieve the bread and other small items and put them in the cart with adult guidance. Another child may need to sit in the cart and practice going in the grocery store for brief periods of time without buying anything, in order to adjust to the stimulation of the store. Both situations are considered engagement, as the grocery store trip had a purpose and a plan for each child. Engagement can also happen in child care settings, community recreation places and at home with the family during natural routines. Service coordinators and the IFSP team will help families identify opportunities for providing engaging activities.

#### 4.4 Direct Instruction/Professional Contact Hours

**The recommended range of direct service hours provided by an IFSP varies from 1 to 20 hours per week. These recommended hours are inclusive of all services (speech therapy, developmental intervention, etc.)** *This recommended level of service should also not be interpreted that children automatically receive the maximum level of service, as a "one size fits all" model. Individualization of services is the priority of the IFSP.*



The decision regarding specific number of hours for direct service should be made by considering the following factors:

- The outcomes identified by the IFSP team;
- The child's age;
- Total hours of engagement the family currently implements;
- The developmental profile of the child;
- Learning characteristics of the child;
- The child's previous involvement in intervention;
- The family's availability for level of service including daily routines of the child and family; and
- Quality and quantity of concerning behaviors (behaviors that are injurious to self or others may indicate a need for more intensive services).

#### 4.5 Who determines intensity and frequency needs?

Decisions about the intensity and frequency are determined by the members of the IFSP team. Members of the team include families, service coordinators, early intervention providers and evaluation/assessment team members, other professionals within the NJEIS and persons requested by the family. Information, assessments and recommendations from physicians, neurologists and other professionals outside of the NJEIS are considered with all other information and clinical opinions. Ultimately, the intensity and frequency of services must be what a child needs to meet the outcomes set forth in the IFSP. Therefore, it will be crucial that teams identify and write appropriate and relevant outcomes and objectively monitor progress for each. See section 4.2 for more guidance on writing outcomes.

Intensity/frequency recommendations also must consider the total hours per week that a child and family participate in activities which in and of themselves provide opportunities for active engagement and learning (e.g. peer play groups, family recreation).

#### 4.6 Why 1- 20 hours?

The National Research Council (2001) recommended a minimum of 25 hours per week of "educational services". This recommendation, however, was based largely on the research of school- age programs (ages 3 and over) and the Council recognized that there are "questions of how best to modify well-established approaches to fit the needs of very young children and their families" (p.151).

The early intervention autism task force undertook a thorough examination of the Council's report and relevant research on early intervention best practice, discussions with stakeholders in NJ, and examination of other state recommendations regarding questions of frequency and intensity. It was the conclusion of the autism task force that for most children in NJEIS, 1-20 hours of direct service will constitute an appropriate plan and will be sufficient to meet the outcomes identified by the IFSP team. Therefore, it is expected that most initial IFSPs will be written for no more than 20 hours of direct service.

However, during periodic review, occurring at least every three months, teams may identify the need for more than 20 hours of direct service. If an IFSP team identifies and is in agreement that there is a need for more than 20 hours of service, a justification must be completed. Once the justification is completed, it is attached to the IFSP service page and a copy of the justification is submitted to DHSS. The updated IFSP is then in effect.

The justification form is contained in Appendix B of this document.

#### 4.7 Gradual Implementation

NJEIS strongly encourages gradual implementation of services involving direct instruction and therapy, especially when a child is very young (less than 24 months). Gradual implementation:

- Provides the systematic method by which the appropriate frequency and intensity level for the child (defined as consistent and measurable progress) can be determined; and
- Allows for the child and family to adjust to the demands of intervention.

#### 4.8 Equal Opportunity to Service: NJEIS Position Statement

The NJEIS decision to have children with the same diagnosis receive different amounts, types and frequency of services may be perceived to be unequal or unfair. However, creating IFSPs that have varying levels of service means the IFSP process is working because individualization of services remains the priority. Recommending that all children will have "X" number and type of services throughout early intervention would make decisions easier for service coordinators, providers and families. Yet, the unique learning styles of the child and strengths and resources of the family must have priority over "standardization" of services. What is standard practice in NJEIS, however, is *equal opportunity* to appropriate and needed services. NJEIS is committed to keeping service coordinators, assessment teams, providers and families, educated about developing appropriate IFSPs that reflect the individual needs of a child and his/her family.

#### 4.9 Choosing a methodology

***NJEIS recognizes that multiple methods and strategies for intervention exist for children with autism. NJEIS does not support, endorse or favor one methodology or "name brand method" over another. Families are encouraged to ask questions and consider all possible methods when making decisions for their child.***

When developing the IFSP, one of the most challenging decisions the team faces is the type of instructional method that will be effective with a child and family.

The National Research Council (2001) noted that:

- "Intervention research is not yet available to predict which specific intervention approaches or strategies work best with which children. No one approach is equally effective for all children and not all children in outcome studies have benefited to the same degree" (p.64).
- "Children with the same diagnosis, gender, chronological age, and IQ score may well have a range of other different characteristics and may respond differently to intervention treatments (p.197).

To support families' full participation in the decisions regarding instructional methods, service coordinators will provide families with unbiased information on treatment options available for children with ASD. Additional assistance in evaluating choices will be available upon family request. All information will be given to families prior to the development of the IFSP.

In the NJEIS, the two most commonly requested types of instructional methods are Applied Behavior Analysis (ABA) and DIR/Floor Time (also known as Greenspan Method). The NJEIS has prepared summaries of each method's salient features that are available to families. These summaries can be found in Appendix C of this document. Service coordinators and early intervention providers should be prepared to discuss with the family, how these approaches can be applied to meet the needs of the child. However, options for families are not limited to these two methods.

#### 4.10 Implications for Using Mixed Methodologies

The IFSP team should be prepared to discuss the implications of choosing more than one intervention methodology. Multiple approaches/methodologies may be appropriate for a child/family, depending on the outcome(s) desired. However, using an eclectic approach or "mixing" several different types of methodologies has drawbacks that need to be presented to families as they consider their options.

Drawbacks include:

- The potential to confuse the child by requiring different responses in similar situations; and
- Difficulty in analyzing which method or strategies are effective or ineffective for the child.

The IFSP team should start with one methodology in order to assess for effectiveness and "fit" for the family. Over time, the choice of methodology may shift based on the child's progress and family comfort with the approach(s). However, the IFSP team needs to give sufficient time to the intervention methodology to determine its effectiveness.

If the IFSP team decides that several methodologies will be used, the goals of all services should be consistent with one another. The team should develop a comprehensive plan so that services complement one another and are consistent. Aspects of other methods that can complement the primary methodology should be discussed.

## 5. Service Providers/Approved Services

### 5.1 Provider Criteria

**NJEIS promotes and supports program providers and interventions that have a strong philosophical base supported by professional literature and clinical data and that have developed curricula and instructional strategies.**

In making their conclusions regarding nationally known “model programs”, the National Research Council noted that “there are virtually no data on the relative merits of one model over another” (2001, 171). Likewise, each of the intervention providers in the NJEIS serving children with ASD is unique in its curriculum and emphasis on intervention strategies, with no data on the merits of one over the other. Therefore, IFSP teams in NJEIS design individual intervention plans for each child based on appropriateness for the particular child and family, not necessarily its adherence to a specific method or model.

NJEIS funded providers will be expected to demonstrate that they use a comprehensive approach to intervention and incorporate these nationally-identified components for successful intervention within their programs for children with ASD. (Hurth, et al., 1999, National Research Council, 2001)

- **Intensity of engagement:** Engagement refers to the amount of time a child is attending to and participating in social and non-social settings and includes sustained attention to a person or developmentally appropriate activity. Engagement may be facilitated by a variety of techniques, materials and activities throughout the day. Engagement includes both incidental teaching and direct instruction.
- **Individualization of services for children and families:** The structure of services, defined outcomes and goals, measurement procedures and instructional settings should be developed according to individual child needs. Additionally, the provision of services is to be based on the child and family's individual strengths and needs.
- **Family involvement:** Early intervention providers will have plans that include support, instruction and feedback to families on carrying over goals and techniques into everyday situations.
- **Systematic, planful teaching:** Intervention and instruction will be well planned, logical and consistent with a theoretical basis, as well as developmentally appropriate and useful.
- **Specialized curriculum:** Curriculum for children with ASD should plan for and address skills in communication (verbal and non-verbal), cognition, play, social interactions and the replacement of inappropriate behavior.
- **Objective measurements of progress:** Providers will have defined standard methods for tracking progress that allow themselves and parents to determine if an intervention is effective for that child. These standards will include objective, observable and anecdotal measurements for use in planning instruction and assessing whether a child is benefiting from a particular intervention.
- **Opportunities for inclusion with typically developing peers in natural environments.** Children should have opportunities for fully inclusive toddler or preschool settings, with appropriate supports, including community child

care and recreational settings. This increases in priority as the child ages, attains skills, and prepares for transition to preschool services.

- **Earliest possible start to intervention:** Research supports earliest possible intervention as an effective practice for children with ASD.

### 5.2 Other Supported Services

The services provided to children by interventionists must be coordinated in order to meet the criteria of "systematic planful teaching". In addition, supervision of interventionists and therapists should occur at regularly scheduled intervals to ensure excellent clinical skills and program quality. To facilitate these requirements, NJEIS will support a ratio of "coordination to level of service".

**IFSPs can reflect a maximum of a (1) one hour bimonthly staff meeting for every 10 hours of service provided. Families should be involved in these meetings to the maximum extent possible.**

### 5.3 Choosing Service Providers/Provider Guidelines

New Jersey has long been one of the leading states for educating children with ASD. However, the availability of options for families varies throughout the state. NJEIS has in place program and professional requirements for all early intervention personnel. These requirements guarantee, not only compliance with federal regulations and maintenance of personnel standards, but also accountability and quality assurance monitoring.

Once the outcomes for a child and family have been determined, an NJEIS service provider will be identified based on the following procedures:

1. When several NJEIS providers are available within NJEIS, the family's choice will be honored.
2. When only one NJEIS provider is available for services, and the program is considered appropriate to meet the needs of the child, the implementation of the IFSP will begin using the available NJEIS provider.
3. When options are presented that include an appropriate NJEIS provider and an appropriate non-NJEIS provider, the NJEIS provider will be assigned. For example, a non-NJEIS ABA provider will not be considered when an NJEIS ABA provider is available just because a different preferred curriculum is used by the non-NJEIS provider.
4. NJEIS providers will not be required to use or fund curricula or methods other than the curriculum/method adopted by their program.

### 5.4 Use of Paraprofessionals

Many programs use paraprofessionals as part of their intervention team. Paraprofessionals are a necessary part of intervention programs, especially when the direct contact hours exceed 5 hours per week. The NJEIS title "paraprofessional" should not be interpreted to mean poor quality or lack of clinical skill. On the contrary, NJEIS paraprofessional personnel have good experience and clinical skill but do not meet the other personnel standards set by NJEIS. Families can be assured that all paraprofessionals are trained and supervised when working with families through the early intervention system.

### 5.5 Services/treatment not supported by NJEIS

The following treatments will not be financially supported by NJEIS:

- Auditory Integration and related therapies;
- Cranial Sacral Therapy;
- Diets (e.g. gluten-free, casein free);
- Dietary supplements/Vitamins;
- Holding Therapy;
- Vision Management Therapy;
- Facilitated Communication;
- Medications (should be noted on IFSP under health/medical information);
- Procedures that are medical in nature and are performed by health care personnel (i.e. Chelation or Secretin)

## **6. Services**

### 6.1 Writing to services on the IFSP

Children eligible for early intervention receive developmental intervention to address developmental delays. They may or may not also be receiving discipline-specific therapy(ies) and family support services. In writing to the services on the IFSP, developmental intervention is listed as the service regardless of the specific "method" such as ABA or DIR that may be used. When a child needs developmental intervention and discipline-specific therapies, the services may be provided by one professional or by two different professionals depending on the knowledge and skills needed for working with the child with ASD. This decision will be made by the early intervention agency providing services to the family based on the knowledge and skills of their personnel. Services may be provided through one-to-one intervention or may utilize a consultative model of intervention.

### 6.2 Indicating Method on IFSP

On the IFSP form, "method" refers to what type of strategies will be implemented. Services are written as "individual or "group" depending on the setting. If the IFSP team decides that the child requires the strategies within a specific intervention methodology, this is noted in the "method" box of the IFSP as well. These strategies should also be described in the strategies section of the IFSP outcome page.

### 6.3 Discipline - Specific Therapy

All determinations of need for a discipline-specific therapy must be made by a licensed professional in that discipline in accordance with NJEIS policies and procedures.

## **IFSP Review**

### 7.1 Review Timelines

The IFSP team evaluates and revises IFSP services on a regular basis. A child's progress should be reviewed at least every three months. Frequent ongoing reviews of the IFSP and of service delivery method are crucial to ensure progress and the appropriateness of services for all children. An IFSP review should include the family, service coordinator, primary interventionist, and other persons requested by the family.

A team may need to convene more regularly if:

- The child is not progressing after a period of approximately three months;
- New concerns arise (e.g. new behaviors, new information, new diagnosis); and/or
- The parents express concern managing the services or incorporating activities into their daily lives.

### 7.2 Modifying Intensity/Frequency of Services

When deciding if an increase or decrease in services is needed, outcome data will be reviewed by the team.

- Consistent progress toward defined outcomes indicates to an IFSP team that current services are effective and the intensity and frequency are appropriate.
- Regression or lack of progress indicates a need to consider different approaches or intensity of service. Changes in service due to lack of progress may include lowering child/interventionist ratios, increasing program time, introducing a new curriculum, or providing additional training or consultation.
- There may be times when it is appropriate to decrease the frequency/intensity of services. Families may have difficulty managing the level of service within their daily routines. During review, the IFSP team may recognize that the child is regressing or showing difficult behaviors. One solution may be to decrease services for a short period of time to determine whether they are too intense for the child and are resulting in diminishing progress.
- Services may also be decreased or changed when the child is meeting goals and developing age-appropriate skills in a particular area.

### 7.3 Disagreements

The research on intervention for children with autism emphasizes "intensity" of services however; there are contradictory opinions and varying definitions of this concept. Should an IFSP team be unable to reach consensus as to the intensity needed for a child to meet the identified outcomes, teams can utilize local and regional technical assistance resources to build consensus of the team.

When a team disagrees and is having difficulty with justifying services beyond the recommended 20 hours, the following steps to resolution should take place:

1. Services that are agreed upon by the IFSP team should begin or continue in accordance with the IFSP.
2. The IFSP must be written with a 45 calendar day review date.
3. Members of the team will complete and submit to the DHSS Autism Project Specialist a request for technical assistance that highlights the areas of disagreement within 2 days of the IFSP meeting. See Appendix E for making a request.
4. The IFSP team will reconvene within 45 days of the IFSP meeting with the Autism Project Specialist as part of the team.
5. Families must be informed of their procedural safeguard rights and options throughout this process.

#### 7.4 Changing Services

The IFSP team is responsible for identifying and correcting problems, should it be determined that methods and strategies of an intervention plan are not working. The team should amend the IFSP to reflect the steps taken and changes made that address the barriers.

Changes to the IFSP may include but are not limited to:

- Redefining the outcomes;
- Identification and remediation of medical issues;
- Increasing or decreasing frequency and intensity of services; or
- Modifying/changing the intervention strategies.

#### 7.5 Planning for peer interaction

One of the eight components of effective practice is “opportunities for inclusion with typically developing peers in natural environments”. In order to meet this program goal, teams will need to assess the needs and capabilities of the child for peer interaction at each periodic review.

### **8. Transition**

#### 8.1 Early Intervention and Transition

Early intervention plays an important role in assisting families with the transition to school-based services. Providers and service coordinators should be cognizant that transition to early childhood settings can be stressful times for families and children as they prepare for a change in service delivery. Transition planning might include some increases in service level and/or shifting of service provision (i.e. more time in integrated play settings and less one-to-one instruction) as needed, to prepare the child for a preschool program. Specific steps for transition are outlined in the NJEIS Policies, Procedures, and Guidelines, and in the NJ Special Education Code. Procedures for transition apply to all children receiving early intervention services, regardless of diagnosis.

#### 8.2 Transition Summary Form

NJEIS has developed a form to assist families in summarizing their thoughts on the intervention techniques and strategies that have been implemented with their child in EI. The opportunity to complete a *Transition Summary Form* (see Appendix D) is available for each family. The purpose of this form is to summarize information on



the intervention plan and progress of the child. A focus on strategies that have been most successful will assist families in organizing their thoughts about transition to new services. This form highlights the child's EI services and supports and may be used to assist a child study team planning evaluations and/or assessments.

### 8.3 Adding activities to facilitate transition

In preparation for transition, it may be appropriate to shift services to incorporate more developmentally appropriate opportunities for peer interaction. This may include planned opportunities for interacting with siblings, play groups, friends, neighbors, and/or a formal child care program/preschool setting. One of the goals of early intervention is to help the family build a natural social network for the child and to develop appropriate skills needed to participate in typical peer interactions. The team should develop specific goals for individual children based on each child's level/skills. For example, sitting appropriately for group activities may be an appropriate goal for one child, while another may be working on turn-taking and reciprocal conversation with peers.

## **9. Concluding Remarks**

In compiling the guidelines put forth in this document, the NJEIS has spent considerable time and attention to balancing the needs of all those who will be directly affected by them, including children and families, NJEIS personnel and the constituents of New Jersey. These guidelines will be monitored in the coming months and years for their effectiveness in meeting the objective they were intended to meet: to assist service coordinators, providers and families in designing quality early intervention for children with autism spectrum disorders.

## REFERENCES

- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, D.C.
- Harris, S. L., & Delmolino, L. (2002). Applied behavior analysis: Its application in the treatment of autism and related disorders in young children. *Infants and Young Children, 14*(3), 11-17.
- Holmes, D.L. (1997). *Autism through the Lifespan: The Eden Model*. Bethesda, MD, Woodbine House.
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- Shaw E., & Odom, S., (2001). *Autism Spectrum Disorders: An update on Policies and Interpretations*. Conference video available from NASDSE. [www.nasdse.org](http://www.nasdse.org).
- Strain, P., Wolery, M., & Izeman, S. (1998). Consideration for administrators in the design of service options for young children with autism and their families. *Young Exceptional Children, Winter*, 8-16.

# Appendix A

NJEIS Definition of  
"Knowledge and experience" in autism

A person considered to have "knowledge and experience in autism" sufficient to take part in evaluation and assessment teams will have the following minimum qualifications:

1. Education and experience that meets one of the early intervention personnel standard positions. This does not include the position of Paraprofessional.
2. Two years professional experience working directly with young children (birth to five) with Autism Spectrum Disorders and their families.

Knowledge, skill, experience, training or education sufficient to express an opinion and explain the basis of that opinion

## Appendix B

## SERVICES OVER 20 HOURS – Justification of Need - Procedure

1. Service coordinator notifies the DHSS Autism Project Specialist or DHSS designated contact person that an IFSP team has or will be recommending services over 20 hours per week. Initial contact can be done by phone, e-mail or fax.
2. Within 2 business days of the team meeting that agreed upon the need for more service, the service coordinator, service provider and family will complete and forward to DHSS the "Justification" information and any supporting documents.
3. The Autism Project Specialist or DHSS designee will review the justification information and any supporting documents and determine if there is sufficient justification for recommended services.
4. During this process, services continue at the level of the IFSP before the submission of a Justification.
5. Within 5 business days of receiving the Justification, DHSS will notify the service coordinator by phone the actions that may be taken based on the Justification documents.
6. Families and service coordinators will receive written notification from DHSS regarding their options for action.
7. Families may proceed with procedural safeguards.

Questions to address in the justification:

1. Does the entire team agree that an increase in service hours is needed?
2. Who is recommending the additional service hours?
3. What outcomes will be addressed by the additional service hours?
4. How has the child adapted to intervention services?
5. How has the family adapted to intervention services?
6. Have modifications to strategies, goals and outcomes been considered or implemented?
7. What methods and strategies are currently successful for which outcomes?
8. What is not currently successful?
9. What level and/or rate of progress does the measurement of outcomes (data) indicate?
10. Have existing service hours been redistributed or modified to meet the outcomes?
11. What family resources are being utilized to facilitate engagement activities?

New Jersey Department of Health and Senior Services  
Early Intervention System  
P. O. Box 364  
Trenton, NJ 08625-0364

**JUSTIFICATION FOR SERVICES OVER 20 HOURS**

Child's Name		Date of Birth
Initial IFSP Date	Review Date	
Date Submitted (Initialed)	Date Received (Initialed)	
Team Members		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
DHSS Review and Comments:		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Signature		Date



**JUSTIFICATION FOR SERVICES OVER 20 HOURS, Continued**[illegible]

## Appendix C

## Applied Behavior Analysis

### What Is Applied Behavior Analysis (ABA)

ABA is the systematic application of the science called Behavior Analysis. ABA therapists use a variety of instructional techniques to improve a person's behavior and then demonstrate that the procedures used were responsible for the improvement of the behavior. The science of ABA and behavior modification has been evolving since 1938 and has been well documented in the professional literature to be an effective teaching method for children with autism. Since it was determined that ABA was useful in teaching children with autism (e.g. Ferster, 1961, Lovaas, 1977) the behavioral approach has advanced in sophistication. Although the curriculum published by Lovaas in 1981 (The Me Book: Teaching Developmentally Disabled Children) became the basis for many programs; most ABA programs today have adopted a more contemporary approach to intervention. Contemporary programs incorporate the advances in the science by using *incidental teaching*, *pivotal response training*, *verbal behavior techniques* and shared control of the teaching interaction (child and adult-initiated interactions) in addition to traditional *discrete trial teaching*.

### What are the goals of ABA?

The overall goal of ABA is to increase appropriate behaviors (skills) and to decrease inappropriate behaviors. This allows the child to engage in meaningful social interactions, acquire needed skills and function as independently as possible. Typically, teaching begins with the learning readiness skills of sitting, attending and following directions. Once the child has learned to attend, more complex and sophisticated skills are taught in a planned and controlled process.

### What about Discrete Trial?

Discrete trial teaching is a structured and consistent method for teaching. Each skill that is to be learned is first broken down into smaller, more manageable steps. This is called *task analysis*. Using discrete trial teaching, the smaller steps of the task are taught individually starting with a clear direction given by the therapist (called Sd). The child then responds correctly or is prompted to carry out the direction. Reinforcement is then given. Trials are repeated several times in a row using the same sequence of instruction. Data are taken on the child's performance. The individual steps of a task are then *chained* together until the entire task can be done independently. Discrete trial allows for the therapist to create a highly predictable learning environment for the child. Discrete trial teaching and ABA are not synonymous; rather it is one technique within ABA.

### Who is trained to provide ABA?

People who teach using ABA receive their training from a variety of sources. Seminars, workshops and clinical practice opportunities are available from schools and agencies in NJ that specialize in ABA and children with autism. New Jersey currently has no standard certification or licensure for ABA interventionists. Nationally, the (BCBA) Behavior Analyst Certification Board Inc. certifies advanced degreed, highly trained persons as Board Certified Behavior Analysts or as Board Certified Associate Behavior Analysts (BCABA).

While this credential identifies the therapist as highly trained in Behavior Analysis, it does not guarantee training in teaching very young children or in autism spectrum disorder.

### Family Roles

ABA techniques can be applied throughout the day both in formal one-to-one teaching sessions and as part of daily routines. Families are taught to use ABA techniques throughout the day and to recognize opportunities for teaching within their daily routines. Families also learn how to recognize the factors that lead to or reward a particular behavior of their child and how to increase or decrease behavior.

### Concerns about ABA

Because many skills are initially taught in isolated discrete trials, oftentimes there are concerns that children will be unable to demonstrate their skills outside of the structured teaching interaction. Quality ABA programs will have procedures and plans for promoting skill generalization and maintenance. Most of the research on ABA programs has been conducted with children who are pre-school age and older. (National Research Council, 2001). The National Research Council (2001) cautioned that there are "questions of how best to modify well-established approaches to fit the needs of very young children" (p.151).

### References:

- Ferster, C.B. (1961). Positive Reinforcement and Behavioral Deficits in Autistic Children. *Child Development*, 32, 437-58
- Lovaas, O. I. (1977) *The Autistic Child: Language Development through Behavior Modification*. New York: Irvington.
- Lovaas, O.I. (1981). *The Me Book: Teaching Developmentally Disabled Children*. Austin TX: Pro-Ed
- National Research Council (2001). *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, Eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

### Further Resources

ABA is a complex and sophisticated method for working with children with autism. We suggest these readings for a more thorough explanation of the terms and concepts presented in this brief description.

- Harris, S.L. & Weiss, M.J. (1998) *Right from the start: Behavioral Interventions for Young children with Autism*. Bethesda, MD, Woodbine House
- Maurice, C., Green G. & Foxx, R.M. (2001). *Making a difference: Behavioral Intervention for Autism*. Austin, TX, Pro-Ed (includes a chapter on *Incidental Teaching*)
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- How to teach pivotal behaviors to children with autism: A training manual.* [www.education.ucsb.edu/autism/behaviormanuals.html](http://www.education.ucsb.edu/autism/behaviormanuals.html)

## Developmental Individual Difference-Relationship Model

### WHAT IS DIRsm?

DIRsm, the Developmental Individual Difference Relationship-based Model is a comprehensive, family-centered approach to assessment and intervention for children with difficulties in relating and communicating. Developed and refined over the last two decades by Stanley Greenspan, M.D. and Serena Wieder, Ph.D., DIRsm is built on the foundation of well-known developmental and learning theories, some dating back to the early 1900s. The cognitive developmental concepts of Piaget, early attachment theory of Bowlby, Mahler's object relations theory, and the learning theories of Vygotsky and Feuerstein, as well as the sensorimotor origins of mental and emotional development are integrated in the DIRsm Model.

Based on the concept that feelings enable us to generate ideas and thought and are the foundation for creative, logical and abstract thought, a basic premise of DIRsm is that thinking and learning begin with our own personal emotional experience, starting first with the child's ability to form relationships and engage in interactions with his caregiver(s). The "R" in DIRsm is the child's capacity to initiate and sustain these relationships.

The child's functional emotional developmental levels form the "D" in DIRsm which consist of:

- 1) being able to stay calm and to take interest in the world;
- 2) forming connections with others in an engaging way;
- 3) communicating with expressions, gestures and eventually, with words;
- 4) connecting movement, affect (emotion) and problem solving;
- 5) functional and imaginative use of language and use of pretend play; and
- 6) emotional problem solving—from the gut, not the head (ex. Why sad?);

The "I" in DIRsm stands for individual, biologically-based differences in the child's ability to process and modulate (take in and make sense of) the information coming into his body through his senses and to plan, sequence and carry out body movements. This includes auditory, visual, tactile (touch), taste, smell, and movement, as well as his perceptions of pain, where his body is in space and underlying muscle tone and strength.

Each child's unique developmental level, sensory profile, motor abilities and regulatory state determine the level and type(s) of intervention. Individual differences, not diagnosis, guide the program.

### WHAT ABOUT FLOOR TIME?

Floor Time, also known as the Greenspan approach, is the heart of DIRsm. A floor time, relationship-based program includes three levels:

- 1) Spontaneous, follow-the-child's-lead floor time;
- 2) Semi-structured problem-solving sessions; and
- 3) Motor, sensory, sensory integration, visual-spatial and perceptual motor activities.

During Floor Time interactions, an adult partner uses the child's natural interests and motivations to encourage his ability to use thinking and problem solving, communication, and motor and sensory exploration in meaningful interactions. Starting with mutual, shared engagement, the child is "enticed" into increasingly more complex interactions in a process known as "opening and closing circles of

communication.” Floor time strategies can be implemented in a variety of settings - in the home, classroom and community settings. Inclusion with typically developing peers is recommended once a child can imitate gestures, sounds or words. Continual re-evaluation of the intervention program is critical as the child progresses and changes.

#### WHAT ARE THE GOALS OF FLOOR TIME?

The goals of Floor Time are to help the child:

1. Become more alert and aware of change;
2. Take more initiative and be less passive in his environment;
3. Become more flexible;
4. Tolerate frustration and change;
5. Sequence longer and more complex actions, plan and execute them;
6. Mediate the process of finding solutions;
7. Communicate gesturally and verbally; and
8. Take pleasure in learning and interacting with others.

Under the goals of floor time, the team works to create a warm, engaging child who recognizes himself as unique, with natural interests and abilities, and who can be motivated to fully participate in the world using these capacities. We want to see a spontaneous, independent and interactive child who can respond to others and the environment with a range of responses.

#### HOW IS THE FAMILY INVOLVED IN FLOOR TIME/DIRsm?

The relationship and interactions between the child and his caregivers is the foundation of the DIRsm Model. The role of the therapist in this model is to coach caregivers and family to develop skills that optimize the child’s developmental progress. This is accomplished during warm, secure, pleasurable, child-led floor time interactions as well as during activities in the daily routine. DIRsm/floor time philosophy and practices are compatible with early intervention best practice in their developmental, individualized, relationship-based, family focus, in the natural environment. DIRsm emphasizes the earliest possible start to intervention and stresses the importance of the earliest stages of development, typically accomplished in infancy.

#### WHAT ARE THE CONCERNS?

Lack of availability of DIRsm trained interventionists makes it difficult for families and school systems to access this approach in New Jersey. Official DIRsm training and certification is currently available only through workshops and seminars under the National ICDL (Interdisciplinary Council on Developmental & Learning Disorders) located in Bethesda, MD. Ongoing parent training is needed as the child progresses through the developmental stages. Another concern is the intense commitment required by caregivers implementing this program on a 24-hour basis

Success in this intervention is measured as the child masters the functional emotional developmental milestones, not by development of specific skills. Due to a strong philosophical base, the literature regarding DIRsm weighs heavily on presentation of hypothesis and theory and less on data-based research. Research is occurring, however, the clinical data collected conforms to less rigorous scientific research criteria than more data-driven approaches.

## GLOSSARY OF TERMS

Sensory processing- the ability to analyze, organize and connect (or integrate) messages coming into the brain from the different senses. It is through this process that the many parts of the nervous system work together so a person can interact with and learn from their environment effectively.

Sensory modulation- the brain's ability to regulate its own activity.

Auditory processing- the ability to receive, identify, discriminate, understand and respond to sound.

Visual processing- the ability to perceive, interpret and respond to what the eye sees.

Tactile system- sense of touch, including pressure, vibration, temperature and pain.

Sensory profile- information collected regarding how a child responds to sensory input in a variety of situations.

Regulatory state- the nervous systems ability to attain, maintain and change levels of arousal or alertness. These levels change according to demands of specific situations and activities.

Circles of communication- a core concept of floor time; the continuous flow of engagement between the child and adult. Example - child opens circle by looking at parent, parent responds by looking back, child responds to parent by smiling or vocalizing, thereby closing the circle.

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Interdisciplinary Council on Developmental and Learning Disorders. Clinical Practice Guidelines Workgroup. (2000). *Interdisciplinary Council on Developmental and Learning Disorders Clinical Practice Guidelines: Redefining the standards of care for infants, children and families with special needs*. Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

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Greenspan, S.I. & Wieder, S. (1997). An integrated developmental approach to interventions for young children with severe difficulties in relating and communicating. *ZERO TO THREE*, 17, 5-18.

Autism Society of America (2001). *Current Interventions in Autism-A Brief Analysis*. Available from [www.autism-society.org](http://www.autism-society.org)

## Further Resources

DIRsm is a complex and comprehensive methodology. The following readings provide a more in-depth explanation of the philosophy, concepts and terms presented in this brief overview.

Greenspan, S.I. & Wieder, S. (1998). *The Child with Special Needs: Encouraging intellectual and emotional growth*. Reading, MA: Addison Wesley.

Greenspan, S.I. (1992). *Infancy and Early Childhood: The Practice of Clinical Assessment and Intervention with Emotional and Developmental Challenges*. Madison, CT: International Universities Press.

*Journal of Developmental and Learning Disorders*. Madison, CT: International Universities Press



## Appendix D

New Jersey Department of Health and Senior Services  
Early Intervention system  
P. O. Box 364  
Trenton, NJ 08625-0364

**TRANSITION SUMMARY**

Date

**DIRECTIONS:** To be completed by parent/guardian with support from Early Intervention staff who are assisting the family with the Transition process. This summary should be completed prior to the Transition Planning Conference held when your child is 30-32 months old. Information summarized is intended to help begin the conversation at the Transition Planning Conference.

Name of Child

Date of Birth

Parent/Guardian

Telephone Number

Street Address

City

State

Zip Code

School District

CTS Case Manager

Telephone Number

Early Intervention Program

Contact Person

Telephone Number

Service Coordinator

Telephone Number

**GENERAL INFORMATION - Please summarize below:**

1. Significant birth history::

## TRANSITION SUMMARY, Continued

### GENERAL INFORMATION, Continued - Please summarize below:

2. Diagnosis or presenting issues:

3. Medical or neurological information:

4. Special or health-related information:

5. Other/medications:

Briefly describe child's program and progress with a focus on strategies that have been most successful (e.g., length of time in Early Intervention, successful strategies, current services, adaptations, etc.):

Family's thoughts approaching transition:

## Appendix E

New Jersey Department of Health and Senior Services  
Early Intervention System  
P. O. Box 364  
Trenton, NJ 08625-0364

**REQUEST FOR TECHNICAL ASSISTANCE**

Child's Name		Date of Birth
Initial IFSP Date	Review Date	
Date Submitted (Initialed)	Date Received (Initialed)	
Team Members		
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In the space below, explain the reasons that assistance is needed. Attach additional information as needed.